

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-010510

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 304A

MAR 20 1962

1. PLACE OF DEATH

a. COUNTY

Greene

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR
TOWN Springfield

Length of stay in 1b

1 week

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR
INSTITUTION Spfld. Baptist Hosp.

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY Wright

c. CITY

OR
TOWN Norwood

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)

ADDRESS

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED

(Type or print)

First

James

Middle

(none)

Last

Heard

4. DATE

OF
DEATH

Month

Feb.

Day

20

Year

1962

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☒Never Married ☐Widowed ☐Divorced ☐

8. DATE OF BIRTH

3/15- 1881

9. AGE (last birthday)

80

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done

during most of working life, even if retired)

Farmer

10b. KIND OF BUSINESS OR INDUSTRY

General

11. BIRTHPLACE (City and state or country)

Seymour, Missouri

12. CITIZEN OF WHAT COUNTRY

U. S. A.

13a. FATHER'S NAME

Ephriam Heard

13b. MOTHER'S MAIDEN NAME

Margarete Krider

14. NAME OF HUSBAND OR WIFE

Maudie Heard

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Blaine Heard-- Norwood, Missouri

18. CAUSE OF DEATH (Enter only one cause per line

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Renal Insufficiency

INTERVAL BETWEEN

ONSET AND DEATH

4 days

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

Adenocarcinoma of the prostate

14 days

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY

PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT

☐

SUICIDE

☐

HOMICIDE

☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF

INJURY

Hour

a.m.

Month, Day, Year

p.m.

20d. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home,

farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 2/13/62 to 2/20/62

and last saw him live on 2/20/62

Death occurred at 12:15 p

m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

William F. Johnson, M.D.

22b. ADDRESS

211 Professional Bldg.

22c. DATE SIGNED

3-16-62

23a. BURIAL, CREMATION,

REMOVAL (Specify)

burial

23b. DATE

2-22-62

23c. NAME OF CEMETERY OR CREMATORY

Donlaw Cemetery

23d. LOCATION (City, town, or county)

Donlow, Missouri

(State)

24. FUNERAL DIRECTOR

ADDRESS

Ewell C. Craig, Mtn. Grove, Missouri

25. DATE RECD. BY LOCAL REG.

3-19-62

26. REGISTRAR'S SIGNATURE

Effie S. Meelon

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

INSTEAD OF

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Cecil C. Craig*

Licensed Embalmer No. *4766*

P. O. Address *Mtn Grove*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 304^A STATE FILE NUMBER

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wright</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Norwood</u>	
Length of stay in 1b <u>1 week</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Spfld. Baptist Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>-----</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>(None)</u> Last <u>Heard</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>20</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-15-1881</u>
9. AGE (last birthday) <u>80</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11. BIRTHPLACE (City and state or country) <u>Seymour, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ephriam Heard</u>		13b. MOTHER'S MAIDEN NAME <u>Margarete Krider</u>	
14. NAME OF HUSBAND OR WIFE <u>Maudie Heard</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT Address <u>Blaine Heard Norwood, Missouri</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) <u>Adenocarcinoma of the Prostate</u>		<u>14 days</u>	
DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>		20f. CITY, TOWN, OR LOCATION COUNTY <u> </u> STATE <u> </u>	
21. I attended the deceased from <u>2.13.62</u> to <u>2.20.62</u> and last saw her/him alive on <u>2.20.62</u> Death occurred at <u>12:15 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>William F. Johnson</u> (Degree or title)		22b. ADDRESS <u>M. D. 211 Professional Building</u>	
22c. DATE SIGNED <u>3.3.62</u>		22d. LOCATION (City, town, or county) <u>Donlow, Missouri</u>	
23a. BURNAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-22-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Donlow Cemetery</u>		23d. LOCATION (City, town, or county) <u>Donlow, Missouri</u>	
24. FUNERAL DIRECTOR <u>Ewell C. Craig Mtn. Grove, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>3-7-62</u>	
26. REGISTRAR'S SIGNATURE <u>Effie E. McLean</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Lewell C. Craig

Licensed Embalmer No.

4766

P. O. Address

Mt. Grove

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

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If this body is not embalmed, fact should be so stated above.

Permit received 2-20-62